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Negotiating Reproductive Policy:
Perspectives on Adolescent Sexuality
in Contemporary Chile

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Abstract

International agreements include within 'reproductive rights' women's right to safe abortion and effective contraception methods, but Chile consistently fails to include legislation and policy allowing universal access to these rights. Pervasive Catholic and conservative forces influence this policy. This establishes a difficult reality for adolescents, whose active and safe sexuality is restricted, contributing to high adolescent maternity rates and high rates of illegal, backstreet abortions. Health professionals frequently diverge on whether these restrictions should be removed. Contrary to the human rights of these adolescents, current policy restricts their access to adequate sex education and reinforces gender inequalities.

Glossary of Terms

- *Comuna*: Municipality; city council
- *Consultorio*: Doctor's surgery, usually larger and serving a wider population than its British counterpart
- *Machismo*: chauvisim; male pride
- *Marianismo*: Idolatry of the Virgin Mary
- *Matrona*: Midwife, delivers social support and advice
- *Pobladora(s)*: (Female) slum dweller(s)
- *Taller(es)*: Workshop(s)

Introduction

This dissertation discusses the politics of reproductive rights in Latin America, focussing on the experiences of adolescent Chileans and their citizenship, situated within feminist discourses on the politics of the body and sexual rights. In the period of democratisation in the 1990s, Chile sought consensus with the Catholic Church, permitting limited space for the reproductive rights debate where it concerns controversial topics such as abortion and contraception.

Petchesky and Judd examine women's own sense of 'entitlement', referring to 'the subjective component of rights (what women *feel* entitled to)' (Petchesky and Judd 1998 p. 12), examining 'under what circumstances such a sense of entitlement emerge[s] in regard to reproductive and sexual decisions and choices' (*ibid*). This approach is central to understanding concepts of citizenship. They develop an analytical framework based on the potential to 'distinguish between the *normative* and the *behavioural*' (*ibid* p. 21), but illustrate their findings on different normative levels: the spheres of law; customs; practice; and 'vision' (*ibid*).

Corrêa (1994) adopts a Southern feminist perspective, offering insight into the importance of cultural relativism and highlighting the drawbacks of universal approaches to rights. Challenging the basic needs approach expounded in the 1980s, she supports integrating choice into discourses on women's empowerment. She identifies debates over feminists' political and organising strategies, and whether 'women should pursue a strategy of structural change versus the incremental transformation of institutions and social practices' (Corrêa 1994 p. 101). A key challenge is to avoid cultural relativism, while simultaneously supporting 'cultural transformation and continuity that respect

women's integrity' (*ibid* p. 103). This approach is important for policy on adolescent sexuality. Petchesky (2003) critiques the transnationalisation of women's movements, health and human rights, situating the struggle for reproductive rights in the wider discourses of economic and social globalisation. She confronts the challenges of 'implementing international norms at the national level' (Petchesky 2003 p. 188). Drawing upon these authors' discoveries and theoretical developments, I present my own investigation.

Objectives

I intend to integrate an understanding of the historical and cultural barriers obstructing women's full access to reproductive rights with the perspectives of health professionals on allegations of gender-based discrimination and limited dissemination of information about sexual rights. I use this information to analyse the policy implications for adolescent motherhood, emergency contraception and abortion.

Chapter 1 presents the reproductive rights discourse, assessing Chile's compliance with international agreements on reproductive rights, the influence of the Catholic Church over policymaking, and its effect on adolescents' realisation of their reproductive rights.

Chapter 2 addresses the discourse on the ideology of motherhood and its intrinsic role in the social and cultural education of adolescents from lower socioeconomic backgrounds.

Chapter 3 presents my fieldwork research, analysing and interpreting perspectives of professionals involved in adolescents' reproductive and sexual rights. It explores the extent to which professionals' perspectives towards adolescent sexuality affect the potential for policy shifts, or signal the perpetuation of prejudice. Chapter 4 contemplates potential space for policymaking in light of these findings.

The study addresses four research questions:

- What implications do the international discourses on reproductive and sexual rights have for adolescents in Chile?
- How are the ideologies of *marianismo* and motherhood produced and reinforced within cultures and what obstacles do they present for adolescents exercising their sexual and reproductive rights?
- What light can professional perspectives shed on the current positioning of adolescent sexuality in relation to education, cultural norms, religion and the international rights discourse?
- What policy implications arise from these perspectives, and how do professionals envisage policy development on adolescent maternity, abortion and developing effective sex education?

Methodology and Research Setting

This dissertation relies upon primary and secondary sources. Research was divided into two stages. The first involved theoretical and historical research pertaining to the struggle of women concerning reproductive rights. In the second stage I spent three weeks in Chile, carrying out semi-structured interviews of between one and two hours, in Santiago and Rancagua (population 200,000; 90km south of Santiago). Among those interviewed in Santiago were a Ministry of Health official, the directors of the Santiago school for *matronas*; doctors, *matronas* and a psychologist in the Hospital Padre Hurtado and *matronas* in the Consultorio El Roble (in La Pintana, a poor *comuna* in southern Santiago). I also interviewed a feminist activist, a university professor and the Director of Región O'Higgins Ministry of Health and three epidemiologists in Rancagua. All interviews have been translated into English.

Ethical Considerations

Each interviewee understood that their opinions would be used and interpreted for the purpose of this study. All names have been changed.

Practical Limitations

Time constraints presented the principal barrier in presenting a representative sample of perspectives. Existing contacts facilitated 17 interviews, but the range of backgrounds was limited and did not include members of the Church, the political right or education professionals.

Many of my informants were reluctant to speak about abortion, hindering discussion on the topic. More time would have allowed formation of a trusting relationship with the research subjects.

Relying primarily on qualitative data, maintaining objectivity is problematic. Where possible I counter subjective data with statistics or secondary sources.

Hypothesis

In developing a hypothesis about adolescents' own perspectives on their sexuality, as seen through the eyes of health professionals, I observed the impact of prevailing cultural and religious ideologies (see Chapter 2) on young people in Santiago, and began to perceive these ideologies as forming a fundamental part of adolescents' understanding of sexuality and body politics. To this end, I developed a hypothesis proposing that even if abortion were legalised, these ideologies would endure, influencing the choices

available to adolescent girls who became pregnant; they therefore inhibit adolescents' ownership of their reproductive rights.

I recognised the potential shortfalls of this hypothesis. Since my research was confined to one particular socioeconomic region of Santiago, I was only able to build evidence for this hypothesis from this area. Moreover, it is important to consider future perspectives and potential shifts in policy, which would affect the way adolescents consider their reproductive rights. However, this hypothesis established a framework within which to conduct my interviews, drawing together the key issues of prevailing cultural norms - the modern society integrated into the global system but reluctant to grant its citizens full active citizenship; and moral and ethical dilemmas faced by health practitioners.

Chapter 1: Politics of the Body: Discourses on sexual and reproductive rights

Without the ability and means to control their fertility and to be self-determined, experience pleasure, and be free from abuse in their sexual lives, girls cannot function as responsible, fully participating members of their families and communities; they cannot exercise citizenship¹

1.1 The Political and Rights Context

This chapter establishes the current reality in Chile regarding state policy towards women's sexual and reproductive rights, considering the international consensuses and the state's measures to ensure that women (including adolescents) have full access to their reproductive rights since ratifying the 1948 United Nations Declaration of Human Rights (UNHDR). The Declaration formed the backbone for all subsequent declarations, including the Convention for the Elimination of all forms of Discrimination against Women (CEDAW, 1979). I consider the state's relationship with citizens regarding individual bodily, sexual and reproductive freedoms in the transition to democracy.

Reproductive freedoms were initially discussed at the World Conference on Human Rights in Tehran in 1968, which recognised couples' 'basic human right to decide freely and responsibly on the number and spacing of their children' (Corrêa 1994 p. 59), followed by the World Conference on Population in Bucharest in 1974, which extended this to individuals; and the 1975 World Conference on Women in Mexico, which recognised that respect for the body 'is a fundamental element of human dignity and freedom (*ibid* p. 57). The individual right to decide the number and spacing of one's children does, however, depend upon states' capacities to assume responsibilities in

¹ Pollack Petchesky, R. 2003. p. 10

ensuring minimum conditions for these rights to be exercised (Maturana Kesten 2004 p 11)².

World Conferences on Population and Development (Cairo 1994), and on Women (Beijing, 1995) followed. Cairo spearheaded the right to a safe sex life, to control fertility, through policies on equality of opportunities like the expansion of education and reproductive health services (Maturana Kesten 2004 p. 12) and recognised the inequalities of male and female power relationships, highlighting the importance of incorporating issues of gender, social equity and human rights. It urged governments ‘to provide adolescents with ... full sexual and reproductive health services and education’ (Corrêa, Petchesky & Parker 2008 p. 169), highlighting different forms of contraception and encouraging men to ‘share responsibility with women in matters of sexuality’ (*ibid*). Beijing encoded the freedom for sexual pleasure (Petchesky and Judd 1998 p. 7). Chile ratified the CEDAW in 1989, and has since been obliged to conform to the Convention.

My definition of reproductive and sexual rights comes from the Report of the International Conference on Population and Development (Cairo, 1994), which I have separated into 3 sections, and addressed from a perspective of adolescents’ reproductive rights:

[1] ‘the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence’³.

² All translations from this author are my own

³ <http://www.un.org/popin/icpd/conference/offeng/poa.html>

[2] 'Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality'⁴.

[3] 'Reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives. Adolescents are particularly vulnerable because of their lack of information and access to relevant services'⁵ [...]

Concerning [2], CEDAW's 36th Session on 7th-25th August 2006 expresses concern that pregnant or nursing adolescents stay in school, stating that:

'pregnancy and maternity shall not constitute an impediment to ... attending an education establishment at any level. Such establishments must moreover grant the necessary academic facilities'⁶

This requires an integrated approach from the Ministry of Education, SERNAM (Servicio Nacional de la Mujer) and the Ministry of Health. Fledgling policies are in place to ensure that adolescent mothers receive adequate care in school and the same quality of education as their peers. However, an investigation of the prevailing ideologies which reinforce the power of *machismo* in poorer regions shows how equity is denied many poorer women trapped in unequal power relationships with men and the state. The implications for adolescents include restriction of sex education and failure to recognise their right to high school education.

⁴ *ibid*

⁵ *ibid*

⁶ <http://daccessdds.un.org/doc/UNDOC/GEN/N04/365/69/PDF/N0436569.pdf?OpenElement>

The CEDAW meeting in June 1999 expressed concern over persistent gender stereotypes, including ‘adolescent girls dropping out of school because of early pregnancy ... [revealing] that deep-rooted social and cultural prejudices persist so as to negatively affect the achievement of equality for women’⁷. Despite improvements on gender equity, quotas, women’s pay and divorce rights over the last decade and the symbolic power of a female president, several interviewees expressed similar concerns, adding that gender discrimination is more prevalent in poorer areas.

Concerning [3], the response to CEDAW’s was that:

‘68% of women between the ages of 16 and 24 use birth control methods, as do 23 per cent of adolescent girls between the ages of 15 to 19. [...] This low rate of use ... is the main reason for the pregnancy rate recorded among girls in that age group (50.5 pregnancies per 1,000 girls). Access to contraception is even more difficult for adolescent girls under 14, and a factor in this may be the law requiring the Public Prosecutor’s Office to be informed of any reproductive health care given to girls in this age group on the grounds that sexual abuse may be involved’⁸.

Adolescent maternity has increased in Chile despite an overall decrease in fertility rates. UN statistics show that in 2002 ‘the average number of children for women under 20 years rose from 0.15 to 0.20, while for the older group [20 to 24 years] the situation was reversed, declining from 0.77 to 0.64’⁹. One obstacle to policymaking is the discrepancy in opinion over the age at which adolescents may be subjects of sexual health and education policy. In government statistics, the age range is 10 - 24, but the Instituto Nacional de la Juventud (National Institute for Youth) indicates 14 - 24. The fact that

⁷ http://www2.ohchr.org/english/bodies/cedaw/docs/ChileCO21st_en.pdf

⁸ <http://daccessdds.un.org/doc/UNDOC/GEN/N06/379/46/PDF/N0637946.pdf?OpenElement>

⁹ <http://daccessdds.un.org/doc/UNDOC/GEN/N04/365/69/PDF/N0436569.pdf?OpenElement>

the rate of teenage pregnancies is rising ‘poses a special challenge to public programmes designed to prevent early pregnancy and to promote family planning’ (*ibid*).

The law commanding investigation of sexually active under-14 year olds conflicts with these adolescents’ human rights. One doctor remarked that many will not seek advice for fear of social stigmatisation, increasing the risk of early pregnancy. He expressed the importance of delivering sex education to children, pre-empting early sexual activity.

Staff in La Pintana referred to a 13-year old mother who had received no prior sex education or contraception advice and hadn’t realised she was pregnant until 3 months later. Such neglect should be addressed in policymaking.

Barriers to the effective compliance with CEDAW’s recommendations rest partly in the concurrence of Chile’s ratification of the Convention and its emergence from 17 years of dictatorship. In searching for a consensus the government has been reluctant to engage in controversial issues. CEDAW expresses concern¹⁰ over the failure to reflect its promises especially on emergency contraception and abortion. Emergency contraception is highly topical at the moment, yet medical staff may still refuse to treat adolescents seeking emergency contraception, and they are legally obliged to report a woman they suspect has had an abortion. Theoretically they may delegate contraceptive care to a colleague¹¹ to maintain the patient’s rights, but when this is not possible the woman is turned away, or given inadequate information. Willmott (1999) and several of my informants relate situations in which human rights are not respected: patients are subjected to patronising treatment, given insufficient information and treated inhumanely (Petchesky 2003). Significant progress has been made in the area of prejudice in

¹⁰ <http://www.un.org/womenwatch/daw/cedaw/36sess.htm>

¹¹

<http://daccessdds.un.org/doc/UNDOC/GEN/N06/379/46/PDF/N0637946.pdf?OpenElement>

treatment, but despite superficial improvements, deep cultural prejudices are harder to penetrate.

1.2 The Feminist Rights Discourse in Socioeconomic and Cultural Context

It is important to outline the evolution of the feminist rights discourse and its relevance for civil society since the transition, to provide a perspective on the relationship between women, their rights, and the state. In mapping the framework which is shifted and constructed through dialogue between different actors – state, Church, feminists, health professionals – we understand the regulations governing adolescents once they become sexually active.

The transition period witnessed the consolidation of the neoliberal paradigm and the reduced size of the state (Maturana Kesten 2004 p. 18). This corresponds directly with policies designed to reduce or eliminate the state's involvement in welfare and social programmes. Neoliberalism promotes 'the idea of individual liberty to choose services, obscuring the fact that this 'choice' remains subject to a person's purchasing power' (*ibid.*: 19). It complicates the implementation of public policy based around equity and civil rights, inhibiting conditions which facilitate all citizens' full and equal access to their sexual and reproductive rights (*ibid* p. 20).

Policy framed in Malthusian terms (population control as a means to development) contradicts the neoliberal framework which sees economic growth as the key development catalyst. Corrêa addresses the scope for feminist perspectives to influence Malthusian debate, but acknowledges the 'backlash of political and religious arguments against women's reproductive self-determinations' (Corrêa 1994 p. 2) and the feminist

critique of the Malthusian population rhetoric which neglects an adequate gender perspective.

Feminists criticise conservative discourses on the 'naturalised' relationship between sexuality, reproduction and family relations (which restrict women's public visibility), referring to the shift from the 'traditional' nuclear framework in modern society, exemplified by the rise in female headed households (Corrêa 1994 p. 3). Family systems are socially constructed yet have a transformative potential to reduce gender inequality, with the right policies.

A paradox is revealed in that neoliberalism sustains a discourse of economic liberalism, yet fails to include the liberty of *individual citizens* in the cultural and private spheres, especially where they concern sexuality, reproduction and the family (*ibid*). 'Resource distribution and shrinking investments in social programmes have characterised 'development' in recent decades' (Corrêa 1994 p. 8), accentuating inequalities and limiting the potential for women's reproductive self determination (*ibid*). This exacerbates the unequal power relationships contained within the public and private spheres. Chile's economic success does not reflect the reality of a society restricted by religious dogmas, inhibiting progress on gender inequality.

Implementing women's reproductive rights requires 'not only supportive laws and policies ... but also a thorough transformation of existing global, regional and national economic structures' (Petchesky and Judd 1998 p. 4). Such structures, embedded in and regulated by the global order, present obstacles to women's empowerment and include childcare and job flexibility, education, political influence and issues of self-esteem (*ibid*). The relevance of international human rights norms for women is crucial. The State

regulates the public sphere, but this is irrelevant for many women whose rights are violated within the private sphere.

Beliefs prevail in religious discourse that women's roles should be restricted to the private sphere, disconnected from public debate (Petchesky and Judd 1998 p. 5). The Church aims 'to buttress the authority of religious laws ... and to reshape national policies and international norms in a conservative mould' (*ibid*), attempting to historicise its norms, resulting in the regulation of women's sexuality. Its influence over politics, legislation and popular opinion ensure Chile's failure to comply with international Conventions (*ibid*), especially on emergency contraception and abortion.

1.3 Shortfalls of the Reproductive Rights Discourse

As Petchesky and Judd (1998 p. 6) highlight, different feminisms exist, expressing different interpretations of reproductive rights; the dominant interpretation is derived from liberal thought. Some interpretations include abortion and others are concerned about the rhetoric of *reproduction* itself and the occlusion of rights connecting sexuality to enjoyment (*ibid*). In Chile, reproduction is presented as a social duty, as is the connection of biological reproduction with *social* reproduction (in which a woman's social circumstances inform her decisions about reproduction) (*ibid* p. 9). Yet there is a gender-specific trend, preparing girls to be mothers from an early age, so women experience their reproduction as 'forms of social labour done for others and demanding considerable organisation, energy and skill' (*ibid*). This normalises sexuality as a purely reproductive duty, containing women's social roles within the private sphere, filtered across generations through power relationships.

Tensions between universalism and relativism mean that liberal theory focuses on the rights of the individual and frequently overlooks kinship and community ties pertaining to different cultures; moreover international legislation assumes ‘that international norms directed at individuals within states are universally applicable and neutral ... [but fail] to recognise that such principles may affect men and women differently’ (Willmott 1999 p. 38). The discourse on human rights has only recently included women, revealing persistent tensions between equality and difference.

1.4 Abortion and Legislation

Abortion is illegal in Chile and unofficial estimates suggest that 150,000 - 200,000 women seek it every year in Chile¹². Abortion may be carried out by a trained practitioner, but services available to most women are unsanitary, performed by untrained practitioners, damaging the reproductive system and may render a woman infertile. Moreover, psychological effects from backstreet abortions can be long-term. Abortion continues to be the principal cause of maternal mortality in Chile¹³.

Many investigations analyse the effects of the criminalisation of abortion on women who have undergone the process (Willmott 1999). Significantly, attitudes reveal ‘a sharp discrepancy between what [women] are willing to say publicly and what they do in practice ... their resistance is the immediate and pragmatic result of punitive laws and religious and cultural sanctions, reinforced by the condemning attitudes of hospital personnel’ (Petchesky and Judd 1998 p. 316). There is a sense that women are as likely to develop opinions on abortion based on fear of suffering ‘as by any moral or religious feelings’ (*ibid*). My informants echoed this sentiment (see Chapter 3).

¹² http://www.cladem.org/espanol/nacionales/CHILE/informe_aborto.asp

¹³ *ibid*

Chapter 2: Motherhood and Abortion in Adolescence

*'When the state regulates women as childbearers it legislates the ideology of motherhood'*¹⁴

2.1 Maternity and Paternity: Reinforced by Religious and Cultural Ideologies

This chapter addresses how the Catholic ideology of motherhood is reproduced in the Chilean narrative and how this affects adolescents and their perceptions of sexuality, their reproductive rights and abortion in the poorer *comunas*. I identify different mythologies and draw links between the ideology of motherhood crystallised by the symbolism of the Virgin Mary and its effects on the adolescent population of Santiago, with focus on the poor *comuna* of La Pintana.

Gender ideology in Chile is profoundly influenced by religion and the Church reinforces 'traditional patriarchal views of women's 'natural' subordination and the primacy of male-dominated, procreative, heterosexual family form' (Petchesky and Judd 1998 p. 5). It attempts to 'normalise what are in fact the values and premises of a particular historical form of social order' (Willmott 1999 p. 50) transmitting them through society and subjugating women, although it may be such an internalised system that women are complicit in it.

It is important to locate adolescents in *poblaciones* in relation to these restrictive symbolic boundaries. Powerful imagery projects 'cultural images on social consciousness ... it is the very fixation of an image as 'natural' which lends it its power' (Melhuus and Stølen 1996 p. 1). This establishes a serious problem concerning conditions in La Pintana, since the most apparently 'natural' images are the hardest to penetrate.

¹⁴ Willmott, C. 1999. p. 181)

The ideology of motherhood is embodied within the *marian* myth. It embodies certain characteristics which have become the norm, but especially in poor *comunias* where struggle is common. 'The Virgin's relationship with her son is characterised by 'self-sacrifice and suffering, [...] which act to contain the degree of power that motherhood offers' (Willmott 1999 p. 54), restricting it to the private space. As with the *favela* women studied by Scheper Hughes (1992), women normalise suffering, passing on this expectation to their daughters.

The cultural construction for masculinity is very different, based around images of power, always in relation to the woman. 'Men are classified along a continuum, in positions relative to each other' (Melhuus and Stølen 1996 p.231), so masculinity shifts and is contested, while 'the moral character of each woman ... is at stake' (*ibid*). The absent father is mirrored in the absent figure of God the father. The principal male/female relationship exists between mother and son; *machismo* therefore gains salience in religious allegory. When situated in the context of a *comuna* like La Pintana, we can observe the parallels between this and reality, how it informs adolescents in choices about motherhood and sexuality. One *matrona* commented that although the religious norms and discourses have a lesser presence in La Pintana, the normalisation of the Catholic form of social order transcends this and affects the way girls think about motherhood (Willmott 1999).

Typically, many pregnant adolescents cannot depend on the adolescent father of their baby, further consolidating the symbolic alliance with the religious narrative. Most pregnancies are not planned, and when asked what contraceptive method they used, most cannot answer. Most adolescents know about contraception, but knowledge is

limited or simply *les da lata* ('they can't be bothered'). Some girls get pregnant to leave home; the image of a single mother with an illegitimate child is more appealing than staying in the familial home, frequently a scene of abuse and poverty. Dr Tomás Vargas explained that in La Pintana drug abuse correlates with adolescent pregnancy.

He indicated that the three spaces that women occupy in Catholic discourse in Chile are mother, wife and housewife (Willmott 1999 p. 55). Frequently, a young couple (if still together) moves away from their families; the man finds a job and is absent during the day. The adolescent mother leaves school (unless a crèche or flexible studying hours are available), staying at home all day engaged on domestic duties. She follows the example of her own mother and exemplifies the Catholic-projected role of the 'good mother', which is her natural role (as opposed to work) (*ibid*). Motherhood establishes her social category. 'For many ... motherhood is the domain where [women] experience the only real gratification and sense of authority they know' (Petchesky and Judd 1998 p. 20). However, this suggests that the 'gender and class inequities of motherhood ... are somehow in the nature of things; that poverty, lack of education and the absence of social supports keep any different, more 'public' identity beyond motherhood virtually out of reach' (*ibid*). The social subjugation of women to men is reflected, therefore, through differential access to the labour market and education.

Many girls from La Pintana know their parents won't pay for education, so university is ruled out. Motherhood is presented by society as 'the most legitimate social space for the woman' (Willmott 1999 p. 55). The status of mother is exalted, representing both respect and virginity. Yet this hyperbolised image of the mother is severely restrictive, damaging women's 'physical integrity or their freedom to make decisions about their own lives' (Petchesky and Judd 1998 p. 20). Malena Vidal, Sociology professor at the

Universidad Humanismo Cristiano crystallised the issue: a professional career is unrealistic for a girl from a poor area, while motherhood offers something which will give her unconditional love, making more sense to someone in her situation.

2.2 The Chilean Historical Narrative

In developing an understanding of cultural syncretism and the anxieties it fosters in Chilean colonial history, Montecino (1991) identifies the problem of *madres y huachos*, in which all Chileans are *huachos* (illegitimate), a word occupying the vernacular, used as a term of endearment among friends and family. The *madre* is the Indian woman, raped by the anonymous, ubiquitous, Spanish *conquistador*. 'Indianness' is 'synonymous with feminine and feminine, in turn, with treachery' (Melhuus 1996 p. 237). The Latin American narrative is based upon this myth: the exclusion of the Indians following the conquest (*ibid*) and the 'invention' of the Chilean nation.

Masculinity, however, is identified by absence and the power to penetrate; 'the male (body) literally and symbolically embodies salient aspects of power and power relations' (Melhuus 1996 p. 241). The post-conquest narrative reaffirms this, through the rape of the (Indian) woman and the land she represents, rendering all *mestizos* illegitimate. Illegitimacy is therefore implicit in the Chilean narrative, creating an accommodating context for adolescents in sexual relations.

These relations are reflected in relationships in Santiago's poorer *comunas*. *Machismo* begins at a young age: children are born into a *machista* household. One *matrona* indicated the most popular boy as the one who sleeps with many girls, who equates using condoms to bathing with socks on. If he doesn't use a condom he is '*lo más super super*'. He is superior to other boys, and desired by girls: 'it is in the eyes of other men that a man's

manhood is confirmed, but it is through women that it is reflected and enacted' (Melhuus 1991 p. 241). Melhuus analyses power relationships between men and women, acknowledging how 'a man's manhood is enhanced ... by the virtue of the women who 'belong' to him' (*ibid* p. 243). The hierarchy of men, 'who need 'bad' women' (*ibid* p. 244) to assert their masculinity, and 'women [who] need indecent women if they are to remain good' (*ibid*) illuminates an inequality between perceptions of potential spaces for sexual expressions for men and women. Perceptions are contained within a masculine idiom, parallel to the *conquistadores'* conquering of Indian women. In each case, the woman's honour is vulnerable. *Marianismo* and *machismo* are strengthened in the national narrative because of the dilemma of origin and identity. For this reason the image of the 'Common Mother' is invoked, parallel to the denial of the *mestizo* identity. It contributes to the construction of an apparently unproblematic identity (Montecino 1991 p. 29)¹⁵.

Opus Dei's strong presence among rightist political elites further accentuates this approach, emphasising woman's central role as mother, disconnected from her body. This 'fundamentalist discourse naturalises the family, sexuality and gender relations and excludes women from the public sphere' (Corrêa 1994 p. 3). There is no space for sexual enjoyment, only work, suffering and reproduction, which finds support in the national narrative.

2.3 Virginity or Motherhood: Implications for Adolescents

The dichotomy of virginity or motherhood, represented in cultural-religious symbols, offers adolescents little space to control their sexuality on their own terms. Moreover, the Chilean narrative, 'which is effectively the continent's own dominant self-interpretation and which [has] relative stability [as a] great cultural myth (Melhuus 1996 p.

¹⁵ All translations from this author are mine

237), ensures that that 'girls are not only brought up to be mothers; ... they are also brought up to be virgins' (Willmott 1999 p. 60). Since sexuality is hidden within the *marian* myth, it is inherently connected to motherhood, and therefore denied through implications of virginity within the myth itself.

Suffering is 'perceived as a female virtue, and forms part of a moral discourse which is exclusive to women and serves to enhance their self-esteem' (Melhuus 1996 p. 248). Women suffer *for* and *on behalf of* their partners and sons, but not the other way around, resolving the problem of female sexuality as potentially virtuous. The connection between 'pure and impure ... represents the shared experience between women and the Virgin, [i.e.] the suffering inherent in motherhood. In a metaphorical transformation, 'virginity' comes to be 'like the Virgin' by virtue of the suffering they have in common' (*ibid* p. 247). Certain types of suffering do not enhance self-esteem and status – for example rape, or abandonment by her children, which both indicate that a woman has not been acting within established cultural boundaries. Suffering as a virtue is arbitrarily constructed, so women are most likely to bear the consequences rather than struggle against them.

Catalina, a *matrona* in the understaffed Consultorio El Roble, drew my attention to the 13-year-old mother whose own mother was only 28. Each week a girl aged between 12 and 16 is admitted to the neonatology unit and the majority are themselves daughters of adolescent mothers. She highlighted their lack of self-esteem, observing that for poorer girls their lives would now be filled with purpose. They believe that 'to be a mother can never be a failure' (Melhuus 1996 p. 248). Pregnancy is a way of escaping their lives and avoiding the position of being a woman *without* a child, which is a matter of concern even for adolescent girls. They become pregnant, even if they do know the risks and how to

avoid pregnancy. Catalina assured me that these girls are not ignorant about contraception; simply *les da lata*. Yet since their sexuality has been denied them through the pervasive image of the virginal Mary, chastity is presented as the opposite polarity and frames women's sexuality within the dichotomy of virgin/mother.

The ideology of *marianismo* replaces sexuality to deliver an ideal for girls, a strong sense of identity and of solidarity with women throughout Chile's history (Montecino 1991 p. 27). Emphasis on suffering and chastity, hyperbolised by the military regime (*ibid* p. 100), restricts adolescents' understandings of their own sexuality - it is denied them in the national discourse on sexual rights.

For most Chilean women, openly discussion of sexuality is taboo. All my informants regretted that adolescents do not receive an honest sex education. They are merely taught the basic biological functions but are not counselled on sex and relationships. For this reason, sexuality is maintained as 'spontaneous, uncalculated and improvised in silence. [...] Planning and discussing contraception spoils sex' (Willmott 1999 p. 62).

This conservative environment is influenced by Catholic doctrine which inspires guilt in pursuing sexuality for pleasure and in which sexuality may be perceived in terms of a religion, exalting submissiveness and devotion to the family rather than realism.

Sexuality in adolescence is not perceived positively and as a consequence is hidden and denied (*ibid*: 60). A perspective of the roots of the myth of hidden and forbidden sexuality is fundamental in order to deconstruct it.

2.4 Sexuality and Abortion: Implications for Chilean Adolescents

Abortion is criminalised in the Criminal Code chapter entitled ‘Crimes against the order of the family, against public morality and against sexual integrity’ (*Aborto Terapeutico*), punishable by 541 days to 3 years in prison. By criminalising abortion, ‘women’s position vis-à-vis the state is ... fixed within maternal responsibility’ (Willmott 1999 p. 114). Despite CEDAW’s approach to the family order, the norms punishing abortion ‘are no longer in accord with the real order’ (*ibid* p. 56). Montecino refers to ‘modern traditionalism’, allowing space for secularisation, but not all that it implies (Montecino 1991 p. 98). These norms prevail in addition to myths fostered in an environment lacking effective, honest sex education.

The professionals I interviewed in La Pintana expressed regret that this must include girls, whose maternal aspirations, lacking clear cultural alternatives, meant that many would have two children by the time they were 20. Those who seek abortion recognise that they have transgressed against the norms prescribed them by the Chilean state and society. At this point they realise motherhood should be desired: that it is not a *natural* state in the way that they had been led to believe (Herrera 2008 p. 606).

The state and the Church regulate adolescents’ sexuality by limiting access to sex education and reproductive rights enshrined by Beijing and Cairo. Lack of honest information about abortion further institutionalises fear. Malena regrets that the state ‘has its head in the sand’, complicating forming appropriate legislation. To use the word ‘abortion’ is to break the taboo and reveal the real events which are pursued beneath. Similarly, policymakers know that sexual relationships do result in abortion, but an educational policy on sexuality is rejected, citing ‘moral values’ (Montecino 1991 p. 117).

Women who seek abortions are generally married, with several children (Willmott 1999; Montecino 1991). For girls under 20, abortion is rarely an option. Aside from being illegal, misinformation about abortion and the significance of motherhood point to reluctance to seek abortion. Malena conceded that, if available legally, it *would* enhance adolescents' ability to exercise their citizenship, by giving them choice and entitlement. Currently, they lack a clear sense of entitlement, which 'intersects with family and sexual dynamics, socio-economic conditions, availability of medical and family planning services' (Petchesky and Judd 1998 p. 14). It incorporates relationships into an understanding of bodily integrity, offering a 'more complex [interpretation] than conventional Western notions of 'privacy' and 'individualism' ... one that postulated the self as *both* individual *and* constructed through ongoing interaction and interdependency with others' (*ibid* p. 15). This would increase adolescents' understanding of their bodily integrity and their right to exercise ownership of their body.

Chapter 3: Professional Perspectives on Adolescent Sexuality

*Without some principle of personhood or moral agency, which is only available through a human rights framework, there is nothing to prevent the state, medical experts or religious authorities from deciding what is good for me on the basis of political expediency, aggregate data or fundamentalist interpretations of scripture*¹⁶

3.1 Introduction

This chapter discusses how professional perspectives reflect dominant ideologies, and whether a rights-based framework, constructed around women's sense of entitlement and citizenship, can counter this. I consider whether a hypothetical situation (legalised abortion) would help to reduce the high rate of adolescent pregnancy, or whether these ideologies are so pervasive that a more significant shift is necessary. I analyse the extent to which the taboo of women's sexuality and restrictions imposed by the state and the Church affect the capacity of health professionals and policymakers effectively to address the problems presented by the lack of effective sex education and contraception and the criminalisation of abortion.

Willmott's interviews with *pobladoras* revealed that 'invariably it is the girl who is seen as responsible for having got herself pregnant because she didn't ... look after herself' (Willmott 1999 p. 144). Parents often adopt a 'repressively controlling' (*ibid*) role during their daughters' adolescence. Under the precept of protecting her honour, this approach contributes to the sense of guilt associated with adolescent female sexuality.

¹⁶ Pollack Petchesky, R. 2003. p. 18

The problems are introduced thematically, and I consider the solutions offered by my informants. I examine how adolescent girls understand their own sexuality, and how they learn about it in the absence of concrete educational policy. I then assess the state of sex education policy in schools, investigate the *talleres* which make up for this absence and investigate how *matronas* engage adolescents with their sexuality. Finally I present my informants' opinions on adolescent abortion. Collating this information, I address my hypothesis, taking into account my informants' evidence.

3.2 Education

3.2.1 Perspectives on Effective Sexual Education Policy

All my informants agreed that the lack of sex education in schools is the greatest obstacle to ownership of sexuality. Carolina is a medical student working in a hospital in San Bernardo, a poor *comuna* in southern Santiago. She highlighted the educational system's regional inequality, where adolescent pregnancy rates correlate with socioeconomic development (17% in San Bernardo, compared to 2% in La Dehesa and Las Condes). Because schools teach what they want and the majority are Catholic, understanding of reproduction is limited, since it is presented in biological rather than sexual terms.

To investigate the quality of sex education, Dr Edmundo Galvéz, Director of the O'Higgins region National Health Service, carried out a survey asking pupils what they knew about sexuality. Most admitted very little, other than biological details taught in school. Knowledge of contraception and sexuality was limited to social and cultural myths. Dr Galvéz lamented the failure of curricula to address this problem and acknowledged that teachers struggle to find the right language to use – demonstrating a strong and pervasive taboo of adolescent sexuality.

Echoing the concerns of the 1999 CEDAW report¹⁷ Cristina, a *matrona* and Malena, an academic, regretted that in poorer schools maths is considered less important for girls, who are taught more about housekeeping. Cristina observed that at home, girls learn indirectly about motherhood from their mothers' and sisters' experiences, forming part of their cultural education, often resulting in adolescent mothers not appreciating the responsibilities of motherhood. Hidden curricula ensure persisting unequal access to education. Malena remarked that it was as if there were many cities within Santiago, when one considers the immense difference in education between *comunas*. Gender inequality is most apparent and most reproduced through the education and cultural systems in areas with low female participation in politics and public life. Yet, even in the *barrios altos*, men don't often share the housework; another woman works as a domestic. Even educated women sustain gender inequalities.

Matilde, a *matrona* in the Consultorio El Roble in La Pintana, complained that sex education comes in small *chispazos* (sparks), but there is no way to sustain the fire. *Chispazos* refer to the programmes run by activists or *matronas* in schools and *consultorios*, but they cannot achieve universal coverage. She thinks the high rate of teenage pregnancy is due to poor education on the part of parents and teachers, careless in their teaching, using euphemisms and myths to preserve taboos. She expressed anger at the Church-imposed restrictions in schools, but indicated that sex education should start in the home, where parents refuse to discuss the topic, hoping to encourage their daughter to preserve her honour. Flora believes the limited sex education at home is a key contributor to levels of adolescent pregnancy and that mothers should teach their daughters about contraception. *Matronas* fill the role of sex educators, but they cannot regularly do this in schools for lack of resources. Flora suggested teaching the best

¹⁷ See Chapter 1, 1.1

students, for dissemination to their peers, but recognised that professional coaching is more effective.

She regularly treats girls of 18 with three or four children. She tells them not to have more children and use contraception, but regrets that they always meet another man who ‘can transform their life’. History repeats itself, and they conceive again. Flora believes one of the biggest issues is adolescents’ lack of self-confidence, awareness of rights, and disillusionment. When she asks if they used contraception, they say ‘no’; when she asks if they wanted to get pregnant, they deny it, not recognising the gravity of the situation; that having unprotected sex is like playing Russian roulette. *Matronas* work hard to influence these girls’ decisions regarding their sexuality, pregnancy and STDs, adopting a psychological, social role. Many girls are depressed, live in squalid circumstances and struggle to open up. *Matronas* visit their houses and realise the severity of the problem – often there is no electricity and no private space.

Lack of consensus on education lead to myths about sexuality and contraception. The withdrawal method is widely trusted, and many *taller* participants believed ‘it was impossible to get pregnant the first time’. Sometimes couples simply don’t use a condom; they know it prevents pregnancy, but myths about contraception are so pervasive, they take this risk. Flora related how a young girl, pre-puberty, asked if there was a difference between sex with and without a condom: she had been told that there was. Flora offered her a condom to touch, showing her how thin it was, explaining that the man doesn’t even realise he’s wearing it, that sex with a condom feels no different to without. She explained how it is a problem of mentality, citing such myths as: ‘it’s like eating a sweet in its wrapper’ or ‘bathing with your socks on’. The visual images conjured are strong, revealing the necessity to dispel such misconception.

3.2.2 Perspectives on *Talleres*: Ambitions, Successes and Failures

Several of my informants had been involved in sex education programmes independent from school curricula. *Talleres* offer adolescents a chance to raise queries and seek advice without stigmatisation. JOCAs (Jornadas de Conocimiento sobre Sexualidad y Reproducción) were designed to converse with parents, teachers and students to dispel myths about sexuality, raising awareness of sexuality using appropriate terminology, contributing to understanding of citizenship, rights, and entitlement. JOCAs ran in many schools, taught differently in each. Those I spoke to who participated in the programmes found that girls were very ashamed of their bodies, treating their bodies almost as a method of payment. They reported that doctors' attitudes when treating them for STDs reinforced this shame. Doctors would say 'what have you done to yourself; you must be more careful'. Sofía, a feminist activist who organised a programme of *talleres* for *pobladoras* and students from the University of Valparaiso, observed the reluctance of women to talk about their sexuality, but the main approach of those delivering the *taller* was to present sexuality as pleasure rather than shame. Since Sofía's *talleres* were run by a small group of feminist activists, they were not as extensive as the group had hoped (for financial reasons and lack of time), but they plan to run more. *Talleres* succeeded in empowering women to feel confident about their sexuality.

JOCAs, though widespread initiatives with significant resources, met with conservative opposition, and dissolved 10 years ago. Dr Carrera thinks the Church has less power now than it did then, and anticipated less opposition now to the idea of community sex education programmes.

There is a fear that civil society will exercise its rights, so it is within parties' interests to maintain the visibility of taboos on discussion of sexuality. Dr Carrera acknowledged that rights are part of the national discourse, but when one considers sexual and reproductive rights, young people are not mentioned – they are not told 'you also have rights' - the right to enjoy a healthy sexuality free from risk. Whenever the Ministry of Education implemented sex education programmes they were confronted with strong conservative opposition and schools were left to teach what they wanted. For Flora the problem is compounded since many parents are religious and don't offer their children any form of sex education; instead they ignore it. The result of this can be observed in the parks of Santiago, havens for young couples who cannot be intimate in their parents' home.

3.2.3 Perspectives on Education for Pregnant Adolescents

Policies are in place to assist those who are already pregnant, but none aim to prevent adolescent pregnancy. *Chile Crece Contigo* prepares women for birth and motherhood, offering social and psychological support, but its presence varies across the city, and in La Pintana it is less integrated, offering fewer social benefits. Since *Chile Crece Contigo* is directed at pregnant women and girls, it excludes those exercising sexuality for other reasons; it rests therefore within the state position on reproduction. Moreover, since religious/cultural norms obstruct 'the 'modernising' influences of economic growth and development on individuals ... conventional family planning programmes [such as *Chile Crece Contigo*] were carefully designed to circumvent cultural resistances by not confronting tradition' (Corrêa 1994 p. 6)

Gabriela, director of the Santiago school for *matronas*, regrets the failure to confront traditions, which prevent sex education from being delivered as a preventative measure,

or universal policy. In San Bernardo's Catholic Hospital Parroquial, only those methods which cannot be interpreted as abortive are taught, including the Billings method¹⁸. It is taught to younger women, but the success rate is low since such methods require discipline and may lead to long periods of abstinence, especially ineffective where single adolescents with no support are concerned. Ownership of and entitlement to women's and girls' sexuality is therefore denied, since their bodies are 'routinely appropriated by others for their sexual and reproductive ends [and they are] both separate from [them] and part of [them] selves at the same time' (Petchesky and Judd 1998 p. 16). The relationship is unequal and is gendered, with women doubly condemned: they are expected to be in control of contraception (but not of their own sexuality), while submitting to their partner's needs, suffering the consequences of unwanted pregnancy.

Matronas and other health professionals all agreed that in terms of family planning, the most effective method, once one pregnancy is under way, was to convince adolescent mothers to make sure that it doesn't happen again, showing how it is a burden on their development. They should be taught methods and techniques to avoid further pregnancy, whether it is natural or barrier contraception, in order to practise responsible sexuality.

3.2.4 Perspectives on Abortion and Education

Carolina feels that the problem with abortion lies in the fact that feminists present it as a solution, instead of encouraging society to aspire to better education. To debate abortion is to lose confidence in the potential for education and experience to avoid it; instead it accepts that an adolescent mother can't cope with the news that she is pregnant. To relieve herself of this trouble, she can abort and may not learn from her

¹⁸ <http://www.billings-centre.ab.ca/general/index.html>

mistake. Carolina regrets the lack of a middle ground between conservative arguments about injustice towards the foetus, and the feminist discourse which may not necessarily reflect society's own view. The problem in Chile is a social incapability to accept abortion as an alternative. Gabriela agrees that legalising abortion isn't a solution, since it would skirt round the real problem, a failure of civil society to engage in political issues. Carolina feels that criminalising abortion instils fear into those who don't comply with the law; the state therefore envisages a utopian society in which there is no abortion.

Gabriela related how, in the conferences she has attended, abortion has never been approached as a topic; neither has unwanted pregnancy. She explained that 'it's not a Chilean topic; people's eyes are closed'. Education on avoiding undesired pregnancy is more sustainable than promoting abortion, since it may have some effect on culture. She feels the problem lies in the lack of active citizenship, of an appropriate and inclusive rights discourse and a secular state. Traditional values are upheld in modern society, which does not unequivocally reflect this traditionalism.

Gabriela opposes abortion, as a result of experiences during her career as a *matrona*. She wants to address and overturn aversion to bringing sexuality into health and education debates. She does, however, believe that abortion should be promoted as a woman's decision about her own body. She supports therapeutic abortion; that it should be a medical decision and a public health issue. She recognises the psychological torture involved in bringing a difficult pregnancy to term. She admits to helping women after spontaneous abortions, but refuses to help women who self-abort.

Some of my informants were reluctant to talk about abortion, and I sensed that they withheld information about cases they had encountered. Health professionals are wary

of approaching the topic. Flora claimed she had never dealt with a self-abortion, but she then referred to cases she had seen, initially telling me that she didn't see girls with post-abortion complications in the *consultorio*, maintaining that if a girl who had provoked an abortion approached her, she would deny her help. She had been faced with this situation twice. Another time a girl had obtained the abortive pill misoprostol, and had taken two, but repented and approached Flora for help, which she received. She acknowledged that unofficial statistics show that abortion rates are higher among women who normally already have a family, rates are increasing among adolescents.

Flora conceded that therapeutic abortion should be legalised, to alleviate pain and suffering. Women facing difficult pregnancies, who know their child will be severely handicapped and may die prematurely, are offered more support, but it isn't sufficient for their needs. In these situations Flora has felt helpless, and she has consequently struggled with her own morality to justify therapeutic abortion. In many cases, mothers receive little support from the father. Because abortion is illegal, women fear confessing to their doctors. Petchesky and Judd identify discrepancies between what women say and do regarding abortion, which are 'the immediate and pragmatic result of punitive laws and religious and cultural sanctions, reinforced by the condemning attitudes of hospital personnel' (Petchesky and Judd 1998 p. 316). Lack of continuity and equal treatment by professionals, in addition to the 'fears of what they have heard ... about women suffering and dying' (*ibid*) exist in addition to fears of abortion on moral or religious grounds (*ibid*). The culture of fear (of suffering and poor post-abortion treatment), surrounding abortion strongly affects exercise of reproductive and sexual rights.

3.3 Cultural barriers

3.3.1 Perspectives on the Culture of Motherhood

‘Sexuality cannot be understood in isolation from the social, political, and economic structures within which it is embedded – or without reference to cultural and ideological discourses that give it meaning’ (Corrêa, Petchesky and Parker 2008 p. 3). Malena criticised the embedded cultural norms which permit a private school student in affluent La Dehesa to set personal goals, supported by her family, while the daughter of an adolescent mother in La Pintana has fewer resources for such remote vocational or educational aspirations. The sense that *la mujer tiene que ser madre* (the woman must be a mother), is more relevant to her situation, and she is more likely to embrace motherhood early. Maternity is, therefore, highly desired in the poorer *comunas*, in itself a form of inequality.

3.3.2 Perspectives on Contraception

An important issue in Chile is emergency contraception. Campaigners pressure for a policy to allow women to experience universal access to the pill and a demonstration demanding legislation occurred during my visit. Currently, the pill’s availability depends on socioeconomic factors, and those in the *barrios altos* find it easier to procure than do women in poorer *comunas*. Yet as I spoke to acquaintances from different social backgrounds about the topic, I noticed reluctance to discuss it, although when pressed most admit they would support a policy which made the pill available. Cristina explained one method employed by *matronas* in the Consultorio El Roble (where emergency contraception is unavailable) is to prescribe a higher dose of the regular combined pill, having the same effect. She needed to justify the method to patients as non-abortive, explaining that it merely restores the woman’s regular cycle. She tells patients about scientific evidence that the regular pill is not abortive. Convictions about the immorality

of barrier contraception seem more marked among the less-educated members of society.

Rosa, (17, from Rancagua) said she collected information about contraception ‘from here and there’; i.e. from friends or siblings, but her knowledge of the most effective method was limited. Some of the more alarming myths reproduced include the belief that condoms procured from hospitals and *consultorios* are less effective than those obtained from richer parts of the city or private clinics. According to Dr Galvéz, less privileged adolescents also wash and reuse condoms. They try to protect themselves, but are misinformed and their actions are ineffective. While young men from affluent Vitacura have condoms in their car and wallet, those from La Pintana must go to the *consultorio*, which adolescent boys will not do, to avoid social stigmatisation. Contraception is the girl’s responsibility. Myths raise doubt over the quality of the *consultorio*, so despite some disseminated information on contraception, obstacles to universal education on effective contraception restrict earnest adolescents’ control over and understanding of their own sexuality.

3.3.3 Perspectives on the Treatment of Adolescents by Medical Staff

Malena mentioned girls treated badly in the *consultorio*, in a form of power abuse on the part of the professional. This fostered mistrust in the quality of the treatment. Girls seeking contraception to avoid pregnancy are more likely to be treated badly than those already pregnant. Doctors use esoteric medical language to mystify the subject.

Religious symbolism is promoted and transmitted through everyday life, threatening women who abort, accusing them of murder. Consequently, even though a woman may have doubts about her pregnancy, she must continue it. Malena maintains that because

abortion is illegal even when life is threatened, the prevalence of these myths is fundamentally wrong and contrary to individual liberty and reproductive rights. Health professionals should not invoke these as a reason to withhold treatment. She echoed the sentiment that recognition of one's own sexual rights, as well as 'the idea of sexual pleasure, its definition, its language, and its expression [should] all ... come from below rather than from above' (Corrêa, Petchesky and Parker 2008 p. 5). She regretted the power of religious and cultural infrastructure to suppress the exercising of women's rights, since this infrastructure *should* uphold 'the right to sexual pleasure by adhering ... to fundamental principles of social inclusion, freedom, and human dignity' (*ibid*).

Other professionals admitted they would probably not treat a woman who had self-aborted, even though they uphold their professional duty to treat patients equally. However, Dr Galvéz felt doctors would not denounce a woman who had aborted, afraid of losing professional credibility. There lacks a unified stance among professionals on abortion to satisfy the religious and human rights discourses and resolve the issue of abortion as a public health problem.

3.3.4 Perspectives on *Machismo*

Matilde believes there is a greater need for a sex education policy corresponding to poor adolescents' circumstances, to effectively *cambiar el switch*, reducing the power of gender roles, the culture of motherhood and promoting responsibility for sexuality. *Machismo* presents an obvious barrier and is reproduced within the family network, particularly prominent among adolescents, forming part of the power relationships between sexes.

All the *matronas* in La Pintana agree that generally, women in the *comuna* suffer low self-esteem. They teach the importance of looking after themselves and knowing their rights.

Discussion always forms part of the sexual education delivered in the *consultorio*. Flora told me how men in the community could have a woman whenever they want; that if one woman resists, they find another, ignoring the consequences. Women have little autonomy, but many of them, she claimed, resist autonomy. The suffering mother, reproduced in imagery and religion, contributes to a sense that it is to be expected - men can't help themselves. During the day the man may shout and hit the woman, and at night he will have sex with her. She has come to accept this as natural and suffers in silence. To encourage women to take pleasure in their sexuality she tells them to look at and to touch their genitals, so they can show their partners how to touch them. This is very hard for the women, because it demands something denied by cultural norms; that is, restricted sexual rights and the sin of female sexual enjoyment. Flora believes the only way to cause a shift in this practice is for couples to attend *talleres* together, and be more sensitive to each other's needs.

Although *machismo* pervades society, its presence is stronger in more deprived areas of Santiago. My informants conceded that there had been shifts in gender power relations, not least with the advent of a female president, but they contended that the impact had been stronger in richer areas. Relationships have become more democratic and traditional power relationships have been rebalanced, but in poorer areas, traditional relationship forms prevail. A continuous trend of *machismo* is reproduced within the family network, where the man is the main provider while the woman stays at home, or seeks work additional to the domestic work.

When consulted about men's aversion to condoms, Flora tells her adolescent patients that they must say 'no'; that men who don't use condoms don't respect them - they will absolve their responsibilities when the girl becomes pregnant. She persuades girls that

contraception doesn't have to be the woman's responsibility, that sex involves two people with equal rights to enjoy it safely.

3.3.5 Perspectives on Adolescent Sexuality

The Church's discourse intrinsically links sexuality to marriage, codified in school curricula promoting 'family life' (Petchesky 2003 p. 242). The existence of 'family planning' rather than reproductive health programmes affects women's ability to exercise their reproductive rights. It denies that young people *have* an active sexuality and fails to provide for and counsel them on it. The Church's influence means that, rather than opposing religious dogmas, the secular state accepts them, integrating them into health and education policy.

Malena maintains that young people should have access to a sex life free from health risks, myths and misinformation, but such access, though to a certain extent legislated, is inhibited by the undercurrent of religious influence over the secular state. Even the progressive parties uphold policies of the post-transition consensus, intrinsically linked to conservatism, so the policies are the same as those of the Right and the Church concerning sexuality, abortion and individual liberty.

3.4 The Rights Debate: Perspectives on the Participation of Civil Society

Paradoxically, Chile is a democratic state with little civil participation. A true democracy might debate abortion and emergency contraception for health reasons, and young people would participate. People I spoke to said they were interested in the topic, but saw no point in debating it because nothing would change. Malena feels that the great weakness is that there is nothing that *truly assumes* the position and policies of a secular

state. Even though there are progressive political perspectives acknowledging the need for effective health and education policies for civil society, these infant policies are ultimately subordinated to the Church's recommendations. The result is public disinterest and disengagement.

Sofia laments that time and resource constraints make movements and campaigns to change the status quo ineffective; but these are the only ways to carve space to manoeuvre in power and increase visibility of the feminist movement. A telephone help line, launched in collaboration with the Dutch NGO *Women on Waves*, providing impartial advice on how safely to provoke an abortion with misoprostol, met significant opposition. Although supporters praise the ambition to reduce the rate of backstreet abortions, the risk of complications is not eliminated¹⁹.

While pressure groups include diverse representatives of society, members are educated, highlighting the tension between Western feminism and 'Southern' perspectives. My informants agreed that Bachelet's government has brought women's issues into public domain and the emergency contraception debate has become more relevant. The conservative right, however, is also a significant actor. Efforts to recruit schoolchildren include taking them out of school to protest against free contraception. Resources and allegiances mobilise civil society in campaigning against legalised abortion. Sofia referred to the difficulty for the feminist movement in forging links with the government. Whenever a feminist joins SERNAM she is compromised, and in a sense Sofia feels that the feminist movement seeks its own marginality.

¹⁹ <http://ipsnews.net/news.asp?idnews=48250>

Chapter 4: Conclusion and Policy Implications

This chapter outlines policy concerns and suggestions offered by my informants as well as considering recommendations by international legislative bodies. I incorporate my findings with perspectives on how the State fails to address fundamental obstacles to these recommendations. The problems I identify here are interlinked, but they have been separated for analysis

4.1 Problems Arising from Current Policy

4.1.1 Lack of Cohesive Sex Education Programmes

Dr Carrera says the Ministry of Health is aware of the need to reduce the disparity between different adolescents' access to sex education. However, it still remains bound within established cultural and ideological restrictions, indicating a wider demand for deeper cultural and policy shifts.

Lack of consensus on the age at which adolescents should be subjects of sexual health education means doctors are legally obliged to report a girl under 14 years who is sexually active, since sex before 16 years old is a crime. Paradoxically, once an underage girl is pregnant, she must carry a pregnancy to term since abortion is not an option. Doctors observe that adolescent mothers are unlikely to return to school, and moreover there is only limited scope for establishing flexible school hours systems and crèches in schools.

All my informants agreed on the efficacy of early targeting in sex education, that it should be preventative, approaching children before they reach puberty. Dr Galv ez referred to his studies of the German education system where he observed kindergarten pupils being taught basic sex education, and the low correlation of adolescent pregnancy connected with this. He believes the Education and Health Ministries should collaborate on policy formulation, and remarked upon lack of dialogue between them. He and Dr Carrera agree that *talleres* must occupy a supporting role rather than the principle role they hold now, in delivering sex education to adolescents. A programme of integrated testimonies, campaigns and *talleres* should highlight the risks involved in being an adolescent parent. By educating through others' experiences, testimonies bring immediacy to the situation, and relevance to real life would encourage participants to open up. These social programmes, together with formal education policy, would be most effective in quashing myths about sexuality.

Corr ea (1994) cites Bruce's 1990 *Fundamental Elements of the Quality of Care*, advocating an improvement in health professionals' 'technical competence combined with interpersonal skills; structural incentives for maintaining availability of an appropriate constellation of services' (Corr ea 1994 p. 86). These recommendations were incorporated into the 1994 Cairo Conference, but Chile still fails to comply adequately with the recommendations. This approach envisaged 'user-friendly services [which assure] greater contraceptive acceptance, continuity and high 'success' rates' (*ibid*).

4.1.2 Family Planning versus Reproductive Health

In framing policy in epidemiological terms, issues pertaining to reproductive and sexual health are bound within religious rhetoric without challenging existing norms connected

to religion and culture. The groups targeted by the *Chile Crece Contigo* programme include pregnant and nursing women and their partners rather than sexually active adolescents, and fertility programmes also neglect to acknowledge adolescents' right to a safe sex life. *Family Planning* as an objective ignores women's right to an 'affirmative assertion of sexuality, as opposed to a defence against sexual abuse or disease' (Petchesky and Judd 1998 p. 16) and also neglects to recognise the multiple family forms in contemporary society, choosing to concentrate on the nuclear family. An integrated policy as expounded in 4.1.1 would ensure steps were taken to avoid this kind of bias.

Effective policy, independent from religious teaching on contraception, is therefore needed, to target adolescents who don't want to equate sexuality with motherhood and want to practise safe, responsible sex without this risk. The 1994 Cairo recommendations include the full participation of men in contraceptive decision-making. In addition to 'voluntary abstinence', (with low success rate among adolescents and failure to recognise psychological impacts of an unfaithful partner during the fertile period), prevailing cultural barriers such as myths about the effectiveness of barrier contraception must be broken down. Men must 'share responsibility with women in matters of sexuality and reproduction' (Corrêa, Petchesky and Parker 2008 p. 169) but for this to happen adolescents must first be subjects of an integrated education system which dismantles preconceptions about contraception.

4.1.3 Lack of Self-Esteem and Sense of Autonomy

Lack of self-esteem is intimately linked to the restriction of citizenship and exercise of rights, which limits the power of the decision-making self to be central to reproductive rights (Petchesky and Judd 1998 pp. 15-16). A focus on improved autonomy must

therefore be encoded within policy formulation, since social implications extend to the widening socio-economic gaps in Chilean society. The intrinsic connection of female sexuality to motherhood intimates its connection as a social obligation rather than an individual right. Yet policy should also be wary of promoting the individual above the social, especially where poor communities are implicated, since ‘putting free choice central to reproductive rights ... bypasses the level of society as a whole. As such, ‘choice’ reflects the dominant view of individualism in the West’ (Corrêa 1994 p. 77). Appropriate policies to recognise women’s social obligations without restricting their sexual empowerment must be devised sensitively, avoiding universalist tendencies.

4.1.4 Rhetoric and Rights

Sofía and Malena both regretted the failure of young people to mobilise and engage in dialogue with the state. Grassroots movements such as *talleres* or demonstrations are effective, encouraging women to be confident in their sexuality and understanding that ‘the idea of sexual pleasure, its definition, its language, and its expression typically come from below rather than from above’ (Corrêa, Petchesky and Parker 2008 p. 5).

Nevertheless, activism may carry the risk of social stigmatisation, so adolescents are reluctant to speak out against the state. Integrated education policies as described in 4.1.1 would offer adolescents the language and rhetoric to empower themselves. Clear recognition of the division human rights into three generations is necessary for this empowerment, yet adolescent sexuality ‘cannot be understood in isolation from the social, political, and economic structures within which it is embedded – or without cultural and ideological discourses that give it meaning’ (Corrêa, Petchesky and Parker 2008 p. 3).

Solidarity with international movements and engagement with worldwide rights discourse should be enhanced, always examining the ways in which power is shifted within the local and private spheres.

4.1.5 Treatment of Adolescents by Health Professionals

Currently, health professionals make decisions about others' lives and bodies, based on their own moral or ethical beliefs. All my informants indicated that on a personal level this is questionable, but as professionals, adopted the accepted norm. They seemed to be divided on what their professional duties entailed, and revealed a discrepancy in what they publicly say they do, and what they do in practice. They should not have to face a dilemma between prioritising ethical beliefs over the moral obligation to ensure the patient's health and autonomy. Relaxed abortion laws would permit abortion specialists, so those morally opposed to abortion would not have to compromise their beliefs.

4.1.6 Abortion and Legislation

According to Dr Carrera, the Ministry of Health recognises the realistic complications of the criminalisation of abortion, the fact that 'social biases and taboos [restrict] abortion to the realm of informal practitioners' (Corrêa 1994 p. 71), and the fiscal burden its illegality presents to the state. He also acknowledged a great problem in that moral judgement and jail sentences don't correspond to the fact that these are *public health* issues.

Carolina believes that abortion should be punished, but that the law functions by frightening those who don't comply with it. She admits it is an indirect tool in the education of society, which should be approached more directly. Others recognised the need to revise the laws on abortion, but all agreed that a more effective solution would be to reduce abortion as an option by improving health policies. They conceded that entrenched social and cultural practices and norms restrict adolescents' involvement in a dialogue with authorities on their sexual rights, and inhibit their psychological ability to see that abortion should form part of their reproductive rights. Dr Galvéz admitted that the culture of motherhood outweighs the discourse on reproductive rights in poorer parts of Santiago and indicated the importance of detaching the exaltation of motherhood from rights, legislation and policymaking. Programmes like *Chile Crece Contigo* should exist parallel to programmes promoting safe, responsible sexuality, but he was reluctant to admit that abortion other than therapeutic should be legalised. Carolina remarked that those who seek to abort do so for fear of being discriminated against at school, for fear that their parents will discover their pregnancy and because they don't want to take on a role not corresponding to their age.

The health professionals were reluctant to engage with the international rights discourse when discussing abortion. It became apparent that for them, abortion was not as relevant as developing more effective integrated health and education policies to improve adolescents' access to sex education. They regretted the unsanitary conditions of backstreet abortions, but didn't all agree that penalties should be relaxed. Carolina couldn't foresee a change in the legislation, but felt that the penalty of imprisonment was justified. Little consensus, therefore, between health professionals on the subject exposes wide discrepancies in the debate on how the topic should be approached.

4.2 Areas of Further Study

Different areas of study on this topic could bring to light more arguments about the policy conclusions I have drawn. A more quantitative analysis would present comparisons between contrasting parts of Santiago, and indeed Chile, and a more extensive qualitative investigation of an area like La Pintana would incorporate a better understanding of adolescents' own perspectives and understandings of their citizenship. Detailed investigation of conservative and religious rhetoric and ideology, especially that of Opus Dei, in poor *comunas* like La Pintana would have enhanced my own investigation.

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